RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION

The Committee on Ways & Means Chairman Richard E. Neal and Ranking Member Kevin Brady are committed to advancing commonsense legislation to improve health care outcomes within underserved communities.

The *Rural and Underserved Communities Health Task Force* (Task Force) is the Committee's forum to convene Members and experts to discuss the delivery and financing of health care and related social determinants in urban and rural underserved areas and identify strategies to address the challenges that contribute to health inequities. Reps. Danny Davis (D-IL), Terri Sewell (D-AL), Brad Wenstrup (R-OH), and Jodey Arrington (R-TX) serve as the Task Force co-chairs, and are working to identify bipartisan policy options that can improve care delivery and health outcomes within these communities.

This *Request for Information* (RFI) solicits input on priority topics that affect health status and outcomes for consideration and discussion in future Member sessions of the Task Force. Terms such as "initiative," "approach," "model," or "demonstration" generally refer to any activity that addresses issues impacting optimal health in these communities.

INFORMATION REQUESTS (Limit each response to 250 words - Total submissions should not exceed 10 pages, 12 pt font):

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

The fundamental issue facing healthcare in rural America is access. This includes access to primary care providers, access to mental health and substance abuse treatment, access to specialists, access to affordable health insurance, and access to affordable medication. 62 of Alabama's 67 counties are considered Health Professional Shortage Areas in regards to primary care, and 66 of Alabama's 67 counties are considered Mental Health HPSAs. This shortage of providers often leaves preventable and manageable conditions untreated, landing patients in local hospital emergency rooms. Yet unfortunately, Alabama has lost 13 hospitals (7 of which were rural) since 2011, and 88% of remaining rural hospitals are operating in the red. Much of this

economic strain can be attributed to a lack of health insurance coverage as roughly 223,000 Alabamians are caught in the coverage gap, unable to afford health insurance. Another 120,000 or more are stretching to pay for private or employer-based coverage. Expanding Medicaid in Alabama would almost completely bridge that gap.

We must also consider the disparate impact of social determinants of health on rural and underserved patient populations. One primary concern for rural Alabama is a complete lack of public transportation. Without transportation, patients have difficulty keeping appointments, obtaining medication, and maintaining their health. In addition to transportation, our patients must have access to clean water and healthy food if they are to stay well. Of course, access to high-quality foodstuffs only benefits those patients who have the heath, dietary, and nutritional literacy to make healthy decisions.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Ryan White-funded agencies, such as Medical Advocacy and Outreach (MAO) in Montgomery, Alabama, demonstrate a wraparound approach to care delivery for people living with HIV (PLWH) that could serve as a model for the broader healthcare industry. Each patient is assigned a social worker and those social workers leverage Ryan White and HOPWA funding, along with linkage to a bevy of other community resources, to ensure that patients have all of their physical and pshyco-social needs met so that their healthcare concerns can be more adequately addressed. As part of these wraparound services, MAO offers a food pantry, transportation, and peer support/healthcare navigation services. Social workers also support insurance navigation and enrollment that helps cut down on unfunded care. An innovative aspect to MAO's approach to care delivery has been the establishment of an extensive rural telehealth network. Through partnerships with the AL Department of Public Health (ADPH), area Federally Qualified Health Centers (FQHCs), and private practice providers, MAO has been able to deliver expert specialty care into some of the most rural, inaccessible regions of the state. The success of this model is clearly demonstrated through viral suppression rates for patients being served through telehealth. Both in their brick and mortar clinics and their telehealth access sites, MAO also employs extensive tracking to ensure their patients are maintaining viral suppression and are being retained in care. Through data-driven enhanced contact, MAO is able to keep patients healthy and troubleshoot issues as they arise, both medical and social.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Ensuring adequate patient volume is absolutely critical for maintaining the solvency of rural healthcare providers and systems. The most fundamental consideration for rural consumers seeking care is health insurance coverage and out of pocket costs. Expanded coverage and low to no out of pocket costs will yield more regular, preventative visits and more predictable income streams for rural providers. Additionally, enhanced health literacy for patients around the need for regular, preventive healthcare will lead to a greater volume of patient encounters. Since rural culture does not stress healthcare as a priority, health literacy in these areas is particularly lacking. Support of tailored, culturally-aware health education in rural communities should be a priority. Patient volume for rural providers could also be bolstered by expansion of options for public transit. It should be noted that even with efficiencies that come from greater volumes of patient visits, it still costs more per capita to treat patients in rural areas than urban areas for all of the reasons previously discussed.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —
a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
b. there is broader investment in primary care or public health?
c. the cause is related to a lack of flexibility in health care delivery or payment?

Fundamentally, it should be noted that FQHCs and community health centers are critical community resources that can provide preventative and primary care, but they in no way supplant the benefits rendered to a community by even a limited-service hospital. We clearly need broader investment in primary care and public health, and these preventative measures will keep people healthier and decrease costs to the healthcare system. Cutbacks in public health funding in Alabama are creating TB outbreaks and third-world parasitic outbreaks, which are being treated at great expense (often as unfunded care) to local hospitals. Additionally, investment in outpatient preventative specialty care creates significant savings for local hospitals. It should be noted that in general, it is harder to bring down costs in rural areas due to the lack of options.

The primary lesson we can glean is that hospitals, FQHCs/community health centers, and public health funding are all critical to maintaining a vigorous healthcare ecosystem in any community. While it makes sense for hospitals to collaborate with community health centers and public health departments to provide unduplicated services in the most efficient, most cost-effective model, it is imperative to communities that each leg of the healthcare stool remains viable.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

As a provider of highly-specialized care, laser-focused on delivering that care to rural enclaves, MAO was an early adopter of telehealth technologies. The model employed by MAO relies heavily on partnerships and collaboration with the AL Dept. of Public Health, local FQHCs, and private family practices to leverage strengths, utilize space & equipment, and share costs most efficiently. As MAO built this system from the ground up, they faced many infrastructure and policy challenges.

First and foremost, rural areas lag significantly in development of high-speed broadband infrastructure, limiting the ability to deliver telehealth services. Make no mistake, expansion of affordable, reliable, high-speed broadband to every hill and hamlet is the rural electrification of our age. Those communities and individual homes left unconnected are relegated to second-tier status, unable to compete academically, economically, or with regard to health outcomes. Any community, particularly rural or underserved, denied broadband access will simply wither and languish on the 21st century vine.

Another significant challenge to the expansion of telehealth services is the reluctance of insurance providers to modernize compensation models, a problem compounded by the general complexity of America's healthcare system. Telehealth commercial insurance coverage laws, like the one passed by Georgia, have made strides toward resolving this issue. Sadly, due to agency capture and legislative lobbying efforts, telehealth reimbursement requirements remain elusive in many states.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Every possible combination of strategies should be employed to avert the current provider shortage and impending rural provider crisis. Focus should first be on recruitment and retention of medical doctors in rural and underserved areas. Models such as Alabama's Rural Medical Scholar Program, the Alabama Board of Medical Scholarship Awards, and Alabama's rural physician tax credit are having a demonstrated impact on recruitment and retention. Sadly though, these state initiatives lack the capacity to solve the shortage. On the national level, the National Health Service Corps (NHSC) loan repayment programs are showing some promise. These programs should be more heavily promoted to pre-professional healthcare students in order to recruit them to HPSAs. Another area of improvement for these loan forgiveness programs could be designating Ryan-White Funded AIDS Service Organizations and HPSA-serving local and state health departments as auto-approved NHSC sites.

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Another consideration for students is the cost of residency education, and The Resident Physician Shortage Act (H.R. 1763) would make significant strides in addressing rural provider shortages by financing residencies.

One great stride in many states has been the expansion of treatment and prescribing capabilities of licensed nurse practitioners and pharmacists. These scope of practice expansions are especially impactful in rural areas that are not currently served by hospitals or medical doctors.

Plans to address health disparities should also leverage specialized professional training programs, such as HRSA's AIDS Education and Teaching Centers. The HRSA AETC model could easily be replicated and adapted to address other specialized health disparities impacting rural and underserved communities.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Numerous approaches have been used in Alabama to address gaps in services for patients with behavioral health issues. Through the utilization of technology, behavioral health providers have expanded their capacity to deliver therapeutic services in rural and underserved communities. These services include screenings and assessments, psychotherapy, non-emergent crisis intervention services, and direct linkages to care. The integration of tele-behavioral health services has been influenced through advocacy efforts at the national and state level through policy development that supports tele-behavioral health services across disciplines. Some of these policies have influenced licensing and regulatory boards to develop standards of practice for clinical and nonclinical disciplines around the following: (1)Technology Capabilities; (2)Program Implementation; (3)Staffing Requirements; (4)Service Fees/Payment Options; (5)Evidence Based Interventions; and, (6)Risk Management. Another approach includes the requirements for providers to receive continuing education and training on the different facets of tele-behavioral health including HIPAA, risk management considerations and cognitive based interventions. Another approach includes the coordination of a state level work group of stakeholders who address the ongoing needs, demands, and challenges around tele-behavioral health service implementation statewide. The convening of a diverse group of providers offers a broad scope of insight around the benefits/barriers to the use of technology, technical assistance and troubleshooting equipment, consumer engagement and input, staff training and development, and steps needed to assure privacy and security. The aforementioned approaches to tele-behavioral health in Alabama have contributed to increased service expansion and a higher quality of care for constituents in rural and underserved communities.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

As part of their regular standard of care, MAO utilizes a model of enhanced communication along with peer support services to boost patient's engagement and retention in care. Most recently, MAO has embarked on the Merck-funded CARE (Creating Access, Retention, & Engagement) Project. This multilevel intervention program addresses barriers to care for MAO's unusually high percentage of women living with HIV (WLWH). CARE addresses many social and structural issues that affect linkage to and retention in care. Through an ongoing series of targeted and evidence-based interventions, the project specifically addresses housing and food insecurity, transportation, lack of social support, stigma, behavioral health issues, and intimate partner violence. Because these aforementioned barriers are exacerbated by the lack of education and employment opportunities that exist in the rural counties that MAO serves, these needs are also addressed through workforce development training. A critical aspect of this project is the utilization of peer health coaches (sometimes called patient advocates or healthcare navigators) to assist patients in accessing care and troubleshooting issues with healthcare systems. Additionally, MAO works to bolster the civic health of clients which has proven to be an effective tool in fighting social isolation. The combination of peer health coaches and civic health training helps to keep patients engaged in the care continuum.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

The federal government has a significant role to play in the standardization of public health definitions and subsidization of critical data infrastructure. Currently, Electronic Medical Records (EMRs) vary widely in the structure of their data output and their coding of conditions, treatments, and charges. For example, Alabama has no integrated data system statewide that is adequate to meet the needs for the End the Epidemic initiatives, and state epidemiological data tends to lag by about 2 years. In order for public health data to be relevant and actionable, it must be as close to real time as possible. Currently, ADPH neither has the funding structure to support those critical integrated data systems, nor do they have appropriate permissions to share data in a HIPAA-compliant way with community based organizations or private practices.

Great efficiencies throughout the healthcare industry could be achieved if there were federal unified coding and EMR guidelines. This standardization of EMR practices could be taken even a step further through a HIPAA Health Information Exchange.

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Such an exchange could be first implemented throughout the network of FQHCs, lookalikes, ASOs, and other federally funded and regulated healthcare providers so that patient data may be shared seamlessly between disparate healthcare entities. Also, this would allow testing of the system in a relatively controlled environment. Eventually, private practice and hospitals across the nation could subscribe to the information exchange so that patients' medical records could be accessible by any provider with proper information security protocols in place.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

- Providers going into service in rural and underserved communities need enhanced training around **cultural competency and sensitivity** toward these populations. This could be accomplished by integrating a rural and underserved lens to traditional medical education, through rural residency programs, and through professional training and CME programs utilizing a model similar to the AETC structure. Special consideration should be given to the general mistrust of the healthcare industry in rural, underserved, and particularly minority populations. Public health professionals & initiatives should be even more sensitive to this mistrust and aware of public health's role in seeding much of this mistrust.
- Many rural and underserved communities across America suffer from chronically poor **primary & secondary education**. This endemic substandard education makes teaching health literacy much more difficult and aspiring to the medical profession unattainable. Patient safety and care quality are directly correlated with a patient's ability to understand their health, comprehend their provider, and be able to advocate for themselves. This ability is grounded in a patient's educational foundation. Any meaningful improvement to the health outcomes for rural and underserved communities will stem from a massive improvement in education. Additionally, high quality primary and secondary education are critical foundations for a medical education. The most culturally competent care will come from products of rural and underserved communities, and those individuals are also the most likely recruits for establishing rural practices.
- **Patient Advocates/Healthcare Coaches** for individuals in rural and underserved populations would provide a significant boost to patient safety and care quality.